SERFF Tracking Number:	*FIVE-125626869*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*38816*
Company Tracking Number:	*508*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Family Protection Plan*		
Project Name/Number:	*/*		

Filing at a Glance

Company: 5 Star Life Insurance Company

Product Name: Family Protection Plan	SERFF Tr Num: FIVE-125626869	State: ArkansasLH
TOI: L04I Individual Life - Term	SERFF Status: Closed	State Tr Num: 38816
Sub-TOI: L04I.500 Other	Co Tr Num: 508	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Mildred Hunt	Disposition Date: 05/02/2008
	Date Submitted: 04/29/2008	Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type:	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/02/2008	
State Status Changed: 05/02/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

WS-UST App R508: 5Star Family Protection Plan Term Life Insurance to Age 100 Application

FPP-I App R508: 5Star Family Protection Plan-I Term Life Insurance to Age 100 Application

FPP-ABDisclosure Form R508: Accelerated Benefit Disclosure Facts

FPP-TI ABDisclosure Form R508: Accelerated Benefit for a Terminal Condition Disclosure Facts

Company and Contact

SERFF Tracking Number:	*FIVE-125626869*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*38816*
Company Tracking Number:	*508*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Family Protection Plan*		
Project Name/Number:	*/*		

Filing Contact Information

Mildred Hunt, Compliance Manager
909 North Washington Street
Alexandria, VA 22314

mhunt@afba.com
(703) 706-5975 [Phone]
(703) 224-0214[FAX]

Filing Company Information

5 Star Life Insurance Company
909 North Washington Street

Alexandria, VA 22314
(703) 706-5975 ext. [Phone]

CoCode: 77879
Group Code: 77879

Group Name: NAIC
FEIN Number: 54-1829709

State of Domicile: Louisiana
Company Type: Life Iinsurance Company
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$80.00
Retaliatory?	No
Fee Explanation:	Per form: 4 x $20.00 = $80.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
5 Star Life Insurance Company	$80.00	04/29/2008	19959694

SERFF Tracking Number:	*FIVE-125626869*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*38816*
Company Tracking Number:	*508*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Family Protection Plan*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	05/02/2008	05/02/2008

SERFF Tracking Number:	*FIVE-125626869*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*38816*
Company Tracking Number:	*508*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Family Protection Plan*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/02/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FIVE-125626869*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*38816*
Company Tracking Number:	*508*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Family Protection Plan*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	5Star Family Protection Plan Term Life Insurance to Age 100		Yes
Form	5Star Family Protection Plan-I Term Life Insurance to Age 100		Yes
Form	Accelerated Benefit Disclosure Facts		Yes
Form	Accelerated Benefit for a Terminal Condition Disclosure Facts		Yes

SERFF Tracking Number:	*FIVE-125626869*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*38816*
Company Tracking Number:	*508*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Family Protection Plan*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: WS-UST App R508

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	WS-UST App R508	Application/ Enrollment Form	5Star Family Protection Plan Term Life Insurance to Age 100	Initial			WS-UST App R508 (Generic).pdf
	FPP-I App R508	Application/ Enrollment Form	5Star Family Protection Plan-I Term Life Insurance to Age 100	Initial			FPP-I App R508 (Generic).pdf
	FPP ABDisclosure Form R508	Other	Accelerated Benefit Disclosure Facts	Initial			FPP-ABDisclosure R508 (Accelerated Benefit Disclosure Facts).pdf
	FPP-TI ABDisclosure Form R508	Other	Accelerated Benefit for a Terminal Condition Disclosure Facts	Initial			FPP-TI ABDisclosure Form R508 (Terminal Condition).pdf

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Admin Offices: 421 S. 9th Street, Suite 222, Lincoln, NE 68508 • 1-866-863-9753

Agent use only—Agent#

Select only one product per app:
○ FPP-CI ○ FPP-I ○ FPP-TI

INTERNAL USE ONLY:

Attachments: Initials:

5Star Family Protection Plan
Term Life Insurance to Age 100
Application

FPP 508 1

USE BLACK OR BLUE INK AND PRINT USING ALL UPPER CASE LETTERS.

Employer Information

Employer

Employer Tax ID # –

Employee Information

Last Name

First Name M.I. D.O.B. / / (Month / Day / Year) ○ Male ○ Female

SSN – – Coverage Amount $, Premium Amount $.

Mailing Address:

Street Line 1

Street Line 2

City State Zip –

Daytime Phone – –

Owner is ○ Self ○ Other _____

Spouse Information

Last Name Owner is ○ Self ○ Other _____

First Name M.I. D.O.B. / / (Month / Day / Year) ○ Male ○ Female

SSN – – Coverage Amount $, Premium Amount $.

Children's Information (ages 0-23) — (The Owner of this policy is the Employee.)*

Child 1:

Last Name

First Name M.I. D.O.B. / / (Month / Day / Year) ○ Male ○ Female

SSN – – Coverage Amount $, Premium Amount $.

Child 2:

Last Name

First Name M.I. D.O.B. / / (Month / Day / Year) ○ Male ○ Female

SSN – – Coverage Amount $, Premium Amount $.

* If you are applying for coverage on more than two children, please complete the "Additional Children's Information" section on the back.

Additional Children's Information

FPP 2 508

Child 3:

Name (First, MI, Last) | DOB | SSN | Sex | Coverage Amount | Premium Amount

Child 4:

Name (First, MI, Last) | DOB | SSN | Sex | Coverage Amount | Premium Amount

Other Insurance

Do you, your spouse, or children have any existing life insurance or annuity contracts? ◯ Yes ◯ No

If yes, and you live in AL, AZ, CO, HI, IA, KY, LA, MD, ME, MS, MT, NH, NJ, NM, NC, OH, OR, RI, TX, UT, VA, VT or WV please complete and sign the Notice: Replacement of Life Insurance and Annuity. The Notice must be ***presented*** and ***read*** to you by your agent at the time he/she takes your application.

Do you, your spouse, or children intend to replace them? ◯ Yes ◯ No

If yes, and you do not live in the above listed states, please complete and sign the applicable state-specific Notice: Replacement of Life Insurance and Annuity.

Beneficiary(ies)

I designate my beneficiary(ies) to receive benefits as indicated below. Check here ❒ if you would like an additional beneficiary form sent to you.

Beneficiary Of Employee Coverage _____
Last Name | First Name | MI | Relationship | DOB | SSN

Beneficiary Of Spouse Coverage _____
Last Name | First Name | MI | Relationship | DOB | SSN

Beneficiary Of Child 1 Coverage _____
Last Name | First Name | MI | Relationship | DOB | SSN

Beneficiary Of Child 2 Coverage _____
Last Name | First Name | MI | Relationship | DOB | SSN

Statement of Health

Answer each question and initial in the box to acknowledge you've read and, TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, understood each question. Circle the specific condition and give full details to any "yes" answers on a separate 8 1/2 x 11 piece of paper.

Initial Here _____

	Employee		Spouse		Child 1		Child 2		Child 3		Child 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
I. In the last 5 years, have you had or been treated by a member of the medical profession for any of the following:												
A. Heart attack, stroke or coronary artery disease?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
B. Any form of cancer to include leukemia and Hodgkin's Disease?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
C. Chronic hepatitis, cirrhosis or other disease of the liver?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
D. Lung disease?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
II. Has the Applicant been diagnosed or treated by a physician, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
III. Have you ever applied for and been rejected for life insurance?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Conditions Relating to this Application

Agreement: I, as employee, have the appropriate knowledge to answer the questions for my spouse and children. I represent that all statements and answers in this application are complete, true and correctly recorded TO THE BEST OF MY KNOWLEDGE AND BELIEF. I agree that: 1) upon approval of this application by 5Star Life Insurance Company, it, the policy and any riders or endorsements will constitute the entire insurance contract; 2) insurance applied for will not become effective until approved by 5Star Life Insurance Company and is subject to the health relating to each person to be insured being as described in this application, and upon receipt of the full first premium, in which case the coverage shall take effect as of the effective date as shown in the policy; 3) if within 60 days of receipt of all required documentation this application is not approved, it will become void and all premiums paid will be refunded; I will be so notified. **Authorization:** I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; financial institution; Medical Information Bureau; or Motor Vehicle Administration that may have records of my financial, physical or mental health condition to give 5Star Life Insurance Company, its authorized representative, and its reinsurers any such information. I understand that this information will be used to determine my eligibility for insurance and that I may revoke this authorization and application at any time by providing written notice. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below. I acknowledge that I, or my authorized representative is entitled to receive a copy of this authorization. As employee, my signature authorizes payroll deduction of premiums from my employer for myself and my family members. **I acknowledge that I have received and read the Accelerated Benefit Disclosure form. Signatures must be personal:**

Sign Here

Employee _____ Date _____

Owner _____ SSN _____
(If different than Employee.)

Signed At (City, State) _____

Agent Certification: I certify that I asked all the questions and had the Applicant sign in my presence. To my knowledge, the Applicant has existing life insurance or annuity coverage. ◯ Yes ◯ No

If yes, are they replacing existing coverage? ◯ Yes ◯ No

Agent Name _____

Agent Signature _____ Date _____

NOTE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement to prison.

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Admin Offices: 421 S. 9th Street, Suite 222, Lincoln, NE 68508 • 1-866-863-9753

Agent use only—Agent#

INTERNAL USE ONLY:
Check Enclosed: ◯ Yes ◯ No ◯ Split
Amt: $
Attachments: Initials:

5Star Family Protection Plan – I
Term Life Insurance to Age 100
Application

FPP-I 508 1

USE BLACK OR BLUE INK AND PRINT USING ALL UPPER CASE LETTERS.

Applicant Information

Last Name
First Name M.I. D.O.B. Month / Day / Year
◯ Male ◯ Female
SSN
Mailing Address:
Street Line 1
Street Line 2
City State Zip
Daytime Phone E–Mail

Spouse Information

Last Name
First Name M.I. D.O.B. Month / Day / Year
◯ Male ◯ Female
SSN

Payor

◯ Applicant ◯ Other (Complete all info below)
SSN/ Tax ID #
First Name Middle Init. Last Name
Address
Daytime Phone No.

Coverage and Premium Amount

Applicant's Coverage Amount $
Spouse's Coverage Amount $
Children's Coverage # of Children x $ 1.00 =

Applicant's Monthly Premium $
Spouse's Monthly Premium $
Children's Monthly Premium $
Total Family Monthly Premium $

Method of Payment
(Please choose one.)
◯ Monthly Checkmatic
◯ Quarterly
◯ Semi-Annually
◯ Annually

Dependent Children's Information (ages 0–18)

FPP-I 2 508

Child 1: ___ – ___ – ____

Name (First, MI, Last) DOB SSN Sex

Child 2: ___ – ___ – ____

Name (First, MI, Last) DOB SSN Sex

Other Insurance

Do you, your spouse, or children have any existing life insurance or annuity contracts? ◯ Yes ◯ No

If yes, and you live in AL, AZ, CO, HI, IA, KY, LA, MD, ME, MS, MT, NH, NJ, NM, NC, OH, OR, RI, TX, UT, VA, VT or WV please complete and sign the Notice: Replacement of Life Insurance and Annuity. The Notice must be ***presented*** and ***read*** to you by your agent at the time he/she takes your application.

Do you, your spouse, or children intend to replace them? ◯ Yes ◯ No

If yes, and you do not live in the above listed states, please complete and sign the applicable state-specific Notice: Replacement of Life Insurance and Annuity.

Beneficiary(ies)

I designate my beneficiary(ies) to receive benefits as indicated below. Check here ❒ if you would like an additional beneficiary form sent to you.

Beneficiary of:

Applicant _____
Last Name MI First Name Relationship DOB SSN

Spouse _____
Last Name MI First Name Relationship DOB SSN

Child 1 _____
Last Name MI First Name Relationship DOB SSN

Child 2 _____
Last Name MI First Name Relationship DOB SSN

Statement of Health

Answer each question and initial in the box to acknowledge you've read and, TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, understood each question. Circle the specific condition and give full details to any "yes" answers on a separate 8 1/2 x 11 piece of paper.

Initial Here _____

	Applicant		Spouse		Child 1		Child 2	
	Yes	No	Yes	No	Yes	No	Yes	No
I. In the last 5 years, have you had or been treated by a member of the medical profession for any of the following:								
A. Heart attack, stroke or coronary artery disease?	◯	◯	◯	◯	◯	◯	◯	◯
B. Any form of cancer to include leukemia and Hodgkin's Disease?	◯	◯	◯	◯	◯	◯	◯	◯
C. Chronic hepatitis, cirrhosis or other disease of the liver?	◯	◯	◯	◯	◯	◯	◯	◯
D. Lung disease?	◯	◯	◯	◯	◯	◯	◯	◯
II. Has the Applicant been diagnosed or treated by a physician, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	◯	◯	◯	◯	◯	◯	◯	◯
III. Have you ever applied for and been rejected for life insurance?	◯	◯	◯	◯	◯	◯	◯	◯

Conditions Relating to this Application

Agreement: I represent that all statements and answers in this application are complete, true and correctly recorded **TO THE BEST OF MY KNOWLEDGE AND BELIEF**. I agree that: 1) upon approval of this application by 5Star Life Insurance Company, it, the policy and any riders or endorsements will constitute the entire insurance contract; 2) insurance applied for will not become effective until approved by 5Star Life Insurance Company and is subject to the health relating to each person to be insured being as described in this application and upon receipt of the first full premium, in which case the coverage shall take effect as of the effective date as shown in the policy; 3) if within 60 days of receipt of all required documentation this application is not approved, it will become void and all premiums paid will be refunded; I will be so notified. **Authorization:** I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; financial institution; Medical Information Bureau; or Motor Vehicle Administration; that may have records of my financial, physical or mental health condition to give 5Star Life Insurance Company, its authorized representative, and its reinsurers any such information. I understand that this information will be used to determine my eligibility for insurance and that I may revoke this authorization and application at any time by providing written notice. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below. I acknowledge that I, or my authorized representative is entitled to receive a copy of this authorization.

I acknowledge that I have received and read the Accelerated Benefit Disclosure form. Signatures must be personal:

Sign Here

Applicant _____ Date _____

Spouse _____ Date _____

Child _____ Date _____
(Parent or guardian must sign if child is a minor.)

Agent Certification: I certify that I asked all the questions and had the Applicant sign in my presence. To my knowledge, the Applicant has existing life insurance or annuity coverage. ◯ Yes ◯ No

If yes, are they replacing existing coverage? ◯ Yes ◯ No

Agent Name _____

Signed At (City, State) _____ Agent Signature _____ Date _____

NOTE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement to prison.

Admin Offices: 421 S. 9th Street, Suite 222, Lincoln, NE 68508 • 1-866-863-9753

5STAR LIFE INSURANCE COMPANY

Accelerated Benefit Disclosure Facts

5Star Life's Accelerated Benefit provides a one-time advance of up to thirty percent (30%) (25% in Michigan) of the policy Coverage Amount upon the occurrence of any one of the following conditions:

HEART ATTACK (Myocardial Infarction): The death of a portion of heart muscle (myocardium) resulting from a blockage of one or more coronary arteries; and requiring hospital confinement for at least three (3) consecutive days.

STROKE: Any acute cerebral vascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 30 days and requiring hospital confinement for at least three (3) consecutive days.

CARDIAC SURGERY: The actual undergoing of bypass surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease, or heart transplant surgery including the use of an artificial heart.

LIFE-THREATENING CANCER: Only those types of cancer manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. As used herein, Leukemia and Hodgkin's Disease (except State I Hodgkin's Disease) shall be considered life-threatening cancer.

LIFE THREATENING CANCER DOES NOT INCLUDE: Any pre-malignant tumors or polyps, cancer in situ, intraductal non-invasive carcinoma of the breast, carcinoid of the appendix, Stage I transitional carcinoma of the urinary bladder, or any skin cancers other than melanoma.

TERMINAL CONDITION: A condition that will result in a drastically limited life span of less than 12 months (24 months in Kansas and Massachusetts).

- The covered condition must first manifest itself on or after 30 days following the Policy's Effective Date.
- The amount paid will reduce the Coverage Amount of the policy by the percentage of the Accelerated Benefit payout. The premium amount due will remain the same.
- A processing charge of $150.00 will be deducted from the Accelerated Benefit payment (except in Nebraska, Florida and South Carolina).
- The benefit paid may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

This form was given to the applicant on _____
Date

Agent Name _____

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)

Admin Offices: 421 S. 9th Street, Suite 222, Lincoln, NE 68508 • 1-866-863-9753

5STAR LIFE INSURANCE COMPANY

Accelerated Benefit for a Terminal Condition Disclosure Facts

5 Star Life's Accelerated Benefit provides a one-time advance of up to thirty percent (30%) (25% in Michigan) of the policy Coverage Amount upon the determination that the Insured has a Terminal Condition.

TERMINAL CONDITION: A condition that will result in a drastically limited life span of the Insured of 12 months or less (24 months or less in Kansas and Massachusetts).

- The diagnosis of the Terminal Condition must be made while the policy is in force.
- The amount paid will reduce the Coverage Amount of the policy by the percentage of the Accelerated Benefit payout. The premium amount due will remain the same.
- The Accelerated Benefit is payable only once in a lump sum.
- The benefit paid may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

This form was given to the applicant on _____
Date

Agent Name _____

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)

SERFF Tracking Number:	*FIVE-125626869*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*38816*
Company Tracking Number:	*508*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Family Protection Plan*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FIVE-125626869*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*38816*
Company Tracking Number:	*508*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Family Protection Plan*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 04/29/2008

Comments:

Attachment:

ARKANSAS Certificate of Readability.pdf

Review Status:

Bypassed -Name: Application 04/29/2008

Bypass Reason: Not applicable

Comments:

Review Status:

Bypassed -Name: Life & Annuity - Acturial Memo 04/29/2008

Bypass Reason: Not applicable

Comments:

5STAR LIFE INSURANCE COMPANY

ARKANSAS INSURANCE DEPARTMENT

READABILITY CERTIFICATION

Re: *WS-UST App R508: 5Star Family Protection Plan Term Life Insurance to Age 100 Application*
FPP-I App R508: 5Star Family Protection Plan-I Term Life Insurance to Age 100 Application
FPP-ABDislcosure Form R508: Accelerated Benefit Disclosure Facts
FPP-TI ABDisclosure Form R508: Accelerated Benefit for a Terminal Condition Disclosure Facts

The undersigned, authorized as Officer to be responsible for policy and related material filings by the officers of 5 Star Life Insurance Company, hereby certifies that the above forms meet Arizona's statutory requirement of a minimum Flesch score of 40.

Glenn R. Jones, Esq.
Vice President of Compliance

Dated: April 29, 2008